Safeguarding Health Benefits

The Hawaii Employer-Union Health Benefits Trust Fund

by
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Introduction

The rising cost of health care today is a serious—if not potentially devastating—threat to health benefits for tens of thousands of public employees and retirees who could face a long-term future with little or no protection from burdensome medical bills without the implementation of new reforms aimed at safeguarding the future fiscal security of Hawaii's health benefits system for public employees.

With an eye on a precarious future for state finances and public employee health care, the Hawaii State Legislature passed a new law (Act 88) during its 2001 session that establishes a health benefits trust fund. The new law addresses many of the problems that have allowed the cost of health care benefits to skyrocket in recent years to a point where health benefits of individual public employees and the state budget are in serious danger.

Issue Overview

…the cost of health care benefits is rising six times faster than the growth of the state budget.

Health benefits are a significant part of the total compensation package for Hawaii's public employees who receive one of the most generous health care packages in the State of Hawaii. And, for public sector retirees and their spouses, the Hawaii Public Employees Health Fund provides one of most generous health benefits packages in the nation. A 1999 survey by the Segal Company, an international consultant and actuary for employee benefit and compensation programs, reports that Hawaii has the national distinction of being:

- One of only 12 states that covers 100 percent of all retirees' health benefits; and
- One of only five states that covers 100 percent of health benefits for retirees and their spouses.

But the generosity of health benefits carries a price. Their cost and a number of other factors, such as rising health care costs and inflation, are threatening Hawaii's ability to care for an aging public employee workforce and a growing population of retirees. It has reached a point where the cost of health care benefits is rising six times faster than the growth of the state budget. From FY95 to FY01, the state General Fund experienced an annual rate of growth averaging less than one percent (0.13 percent),

while health care costs for active and retired public employees grew at an average annual rate of 6.0 percent. Annual appropriations for Health Fund premiums rose from $164 million to $232 million during the same period.

The cost of health benefits has become one of the biggest items in the state budget. Without reforms, public employee health benefits by FY03 are projected to cost the state $284 million which exceeds the combined budgets of the 13 smallest state departments and offices by $42.9 million.

In future years, health care costs in Hawaii will consume an even larger share of the budget. In FY02, the cost of health benefits takes up 7.1 percent of the General Fund. Without reforms, the cost of health benefits by FY07 is projected to comprise 11.2 percent of the state General Fund—exceeded only by the individual budgets of higher and lower education and the departments Health, Budget and Finance, and Human Services.

A Legislative Auditor's study in 1999 identified other factors driving up the overall cost of health care for public employees. Among the findings: Hawaii was the only state in the nation that allowed public employees to choose between health plans offered by public employers and public employee unions. The Auditor found that this competition between plans offered by employer and unions was a major factor for higher state and county costs for health benefits and higher premiums for beneficiaries.

High-risk employees who needed more medical attention generally subscribed to more costly plans with the Hawaii Public Employees Health Fund, while low-risk employees who required less medical attention migrated to relatively inexpensive, union-sponsored plans. This inadvertently segregated high-risk and low-risk employees which the Auditor called "adverse selection."

Meanwhile, the state was still required by law to pay contributions to employees enrolled in both the Health Fund and union-sponsored health plans, with payment levels determined by the cost of the most popular Health Fund plans which, due to adverse selection, are the more expensive plans. The result of "adverse selection" and the transfer, or "porting," of employer contributions to the unions was higher costs to public employees and the state and county employers. The Auditor concluded that as long as "adverse selection" continued, health benefit costs would continue to escalate.

The new law adopts the Auditor's recommendations to reform inefficiencies….

The Auditor's findings guided the 2001 Session of the Hawaii State Legislature to enact a new law (Act 88) establishing the Hawaii Employer-Union Health Benefits Trust Fund and a governing Board of Trustees. The new law adopts the Auditor's recommendations to reform inefficiencies in the health benefits system and to safeguard health benefits for all active and retired public employees by:

- Combining all public employees into one health benefit program. The Trust Fund creates a single, larger group of beneficiaries comprised of active and retired employees. This enhances the employer's ability to negotiate favorable rates with health insurance carriers and eliminates "adverse selection."

  The elimination of "adverse selection" and "porting" will help control the rising cost of health benefits. Creation of a single health benefits program also eliminates duplicative administrative costs.

- Establishing a formula, based on existing rates adjusted for inflation, that determines the state's contribution levels for retiree health benefits. The formula will provide fundamental cost control.

  Under the system now in place, the Health Fund designs plans to provide retirees' health benefits, without regard to cost. The new Trust Fund will be able to use the formula to define the state's contribution levels and still provide retirees with health plans that are comparable to what they receive now.

- Empowering the Trust Fund's Board of Trustees to design health benefit plans and the flexibility to react to changes in the marketplace. It is a nationwide trend: Employers in both the private and public sectors are engaged in efforts to find creative ways to offer health benefit plans to employees, while

safeguarding long-term fiscal resources to pay for benefit plans available in today's medical marketplace.

In Hawaii, the Trust Fund's board has the authority to design and to approve new health plan designs that are comparable to existing plans beneficiaries now receive and other plans that offer greater flexibility and choice to beneficiaries.

The legislative mandate of the Hawaii Employer-Union Health Benefits Trust Fund's Board of Trustees is to design and to approve health benefits packages that will offer flexibility and choice to all beneficiaries. At the same time, the health benefits plans will address the fiscal challenges now facing the health benefits system. The board—comprised equally of employer and union representatives—has convened and will work toward the implementation of new health coverage plans by July 1, 2003.

The new trust fund presents a solution to a pressing problem by correcting inefficiencies in Hawaii's health benefits system and safeguarding the fiscal strength of a dependable, high-quality health coverage system for Hawaii's 83,000 state and county government employees and retirees.

The Problem: Rising health care costs and premiums

Without the reforms of Act 88, rising health care costs and inflation will become even greater threats to the fiscal strength of the health care benefits system for public employees. The cost of caring for an aging population of state and county employees and retirees, as well as future generations of public employees, is now among the fastest-growing items in the state budget.

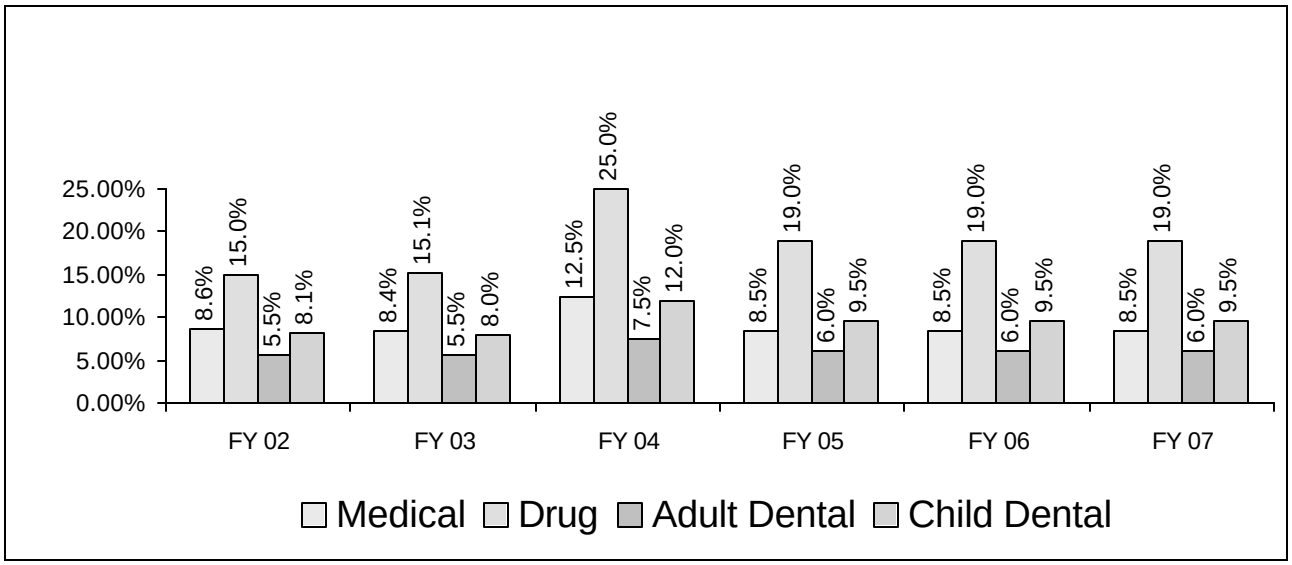
In recent years, rising health care costs have been reflected in monthly premiums the state pays for retirees eligible for Medicare who have experienced substantial increases in monthly premiums from FY94 to FY02 when:

- HMSA family plans soared 30 percent from $219.16 to $285.00; and
- HMSA family drug plans shot up 240 percent from $71.44 to $243.04.

Active employees also saw monthly premiums increase. From FY94 to FY02, total monthly premiums for active employees rose dramatically:

- HMSA family medical plans increased 31 percent from $362.16 to $474.08; and
- HMSA family drug plans skyrocketed 241 percent from $34.56 to $117.84.

Figure 1: Projected Health Fund premium increases



If nothing is done to try to control these rising costs, Health Fund premiums for medical, drug, and adult/child dental plans will post dramatic annual increases from FY02 to FY07—led by double-digit increases for drug premiums in each of those six years (*see Figure 1, above*). The largest single-year increase during that period is projected to occur in FY04, when:

- Drug coverage will increase 25 percent;
- Medical coverage will increase 12.5 percent; and
- Child dental coverage will increase 12 percent.

Health care taking greater share of state budget

Over the years, Health Fund appropriations have grown to become one of the largest single items in the General Fund. Unless corrective action is taken, the total state appropriations that cover employer contributions to the Hawaii Public Employees Health Fund will consume a larger and larger share of the General Fund from FY93 to FY07:

- Appropriations for the state Health Fund will rise from $117 million to $447 million, unless reforms are made to the health benefits system *(Figure 2)*; and
- Appropriations for the Health Fund—as a percentage of the General Fund—are projected to more than quadruple from 3.8 percent to 11.2 percent, without reforms *(Figure 3)*.

Figure 2: State General Fund Appropriations for Health Fund, FY92-FY07

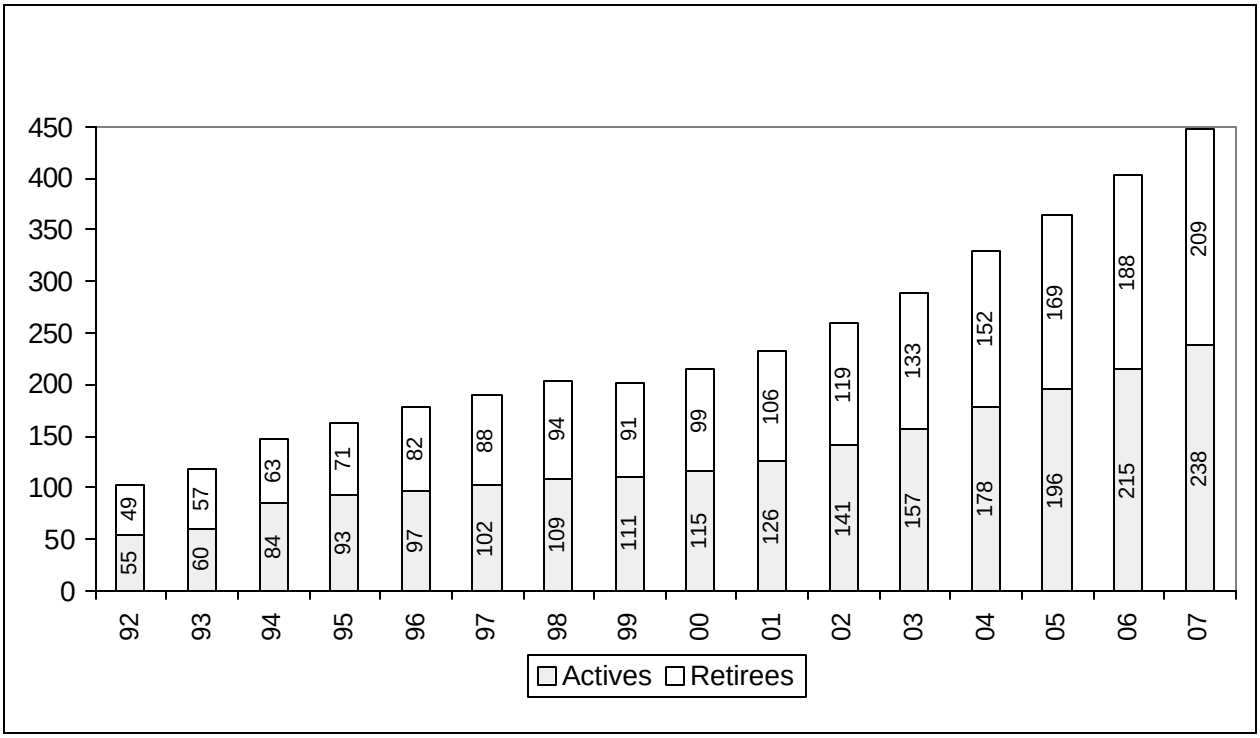
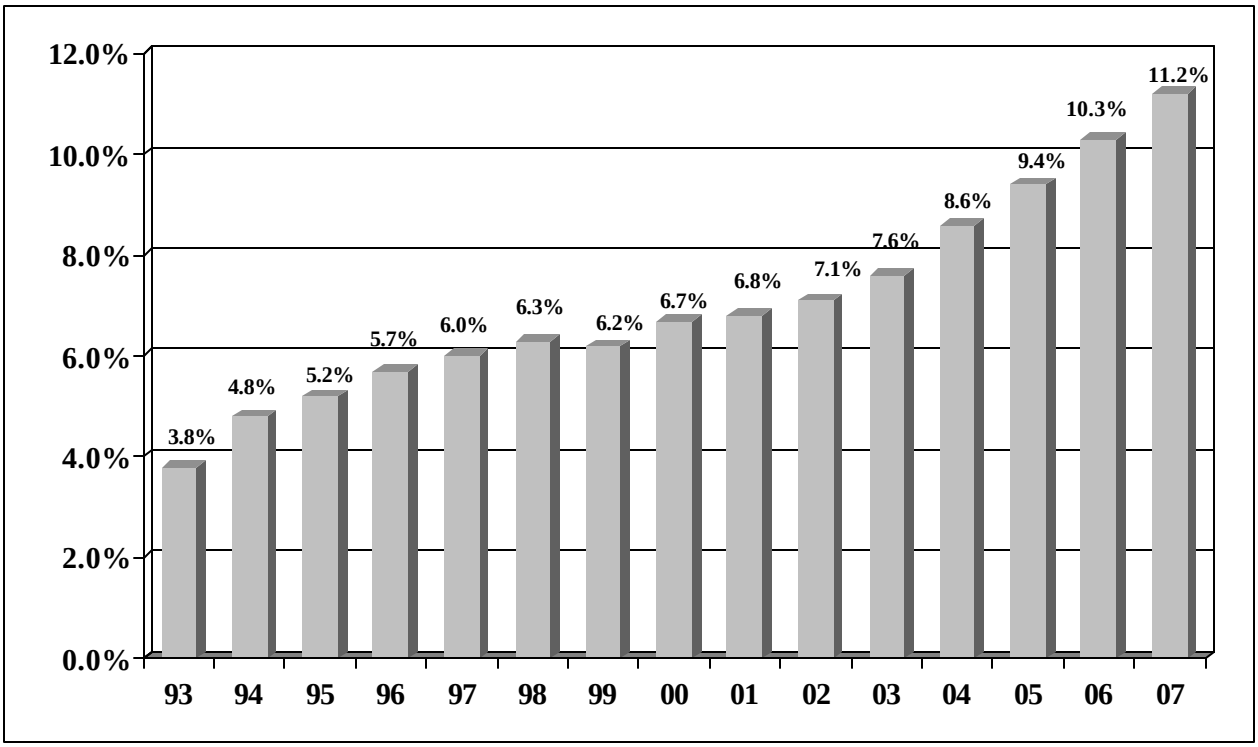


Figure 3: Health Fund Appropriations as percent of General Fund (estimated expenditures FY93-FY07)



In FY03, the projected cost of health benefits exceeds the appropriations for the operating budgets of 13 state departments and offices (*see Figure 4, below*). The projected cost to the state of $284 million for public employee Health Fund premiums in FY03 is well above the combined operating budget of $241.2 million for 13 of the smallest state departments.

Meanwhile, the annual growth rate of the state budget has not been able to keep pace with rising Health Fund appropriations which are increasing six times faster than the state budget. From FY95 to FY01, the annual rate of growth of the state General Fund was .13 percent. During the same period, the annual rate of increase for Health Fund premiums was 6.0 percent, as Health Fund appropriations rose from $164 million to $232 million.

Figure 4: Comparison of Health Fund premium costs and department budgets

Department	FY 03 Operating Budget	Percent of General Fund	Cumulative
Hawaiian Home Lands	$1.3 million	0.03	1.3 million
Governor	$3.7 million	0.10	5.1 million
Lieutenant Governor	$4.1 million	0.11	9.1 million
Defense	$8.2 million	0.23	17.4 million
Agriculture	$11.7 million	0.32	29.0 million
Human Resources Development	$13.4 million	0.37	42.4 million
Labor and Industrial Relations	$16.1 million	0.45	58.6 million
Taxation	$16.8 million	0.47	75.4 million
Business, Economic Dev., Tourism	$19.0 million	0.53	94.5 million
Attorney General	$21.1 million	0.59	115.7 million
Libraries	$22.7 million	0.63	138.4 million
Land and Natural Resources	$24.5 million	0.68	162.9 million
Accounting and General Services	$78.3 million	2.17	241.2 million
Public Safety	$147.2 million	4.07	388.4 million
Health	$401.0 million	11.11	789.4 million
University of Hawaii (with fixed costs)	$438.3 million	12.14	1.2 billion
Budget and Finance (Excluding UH/DOE fixed costs)	$531.5 million	14.73	1.8 billion
Human Services	$539.0 million	14.94	2.3 billion
Department of Education (With fixed costs)	$1.3 billion	36.31	3.6 billion

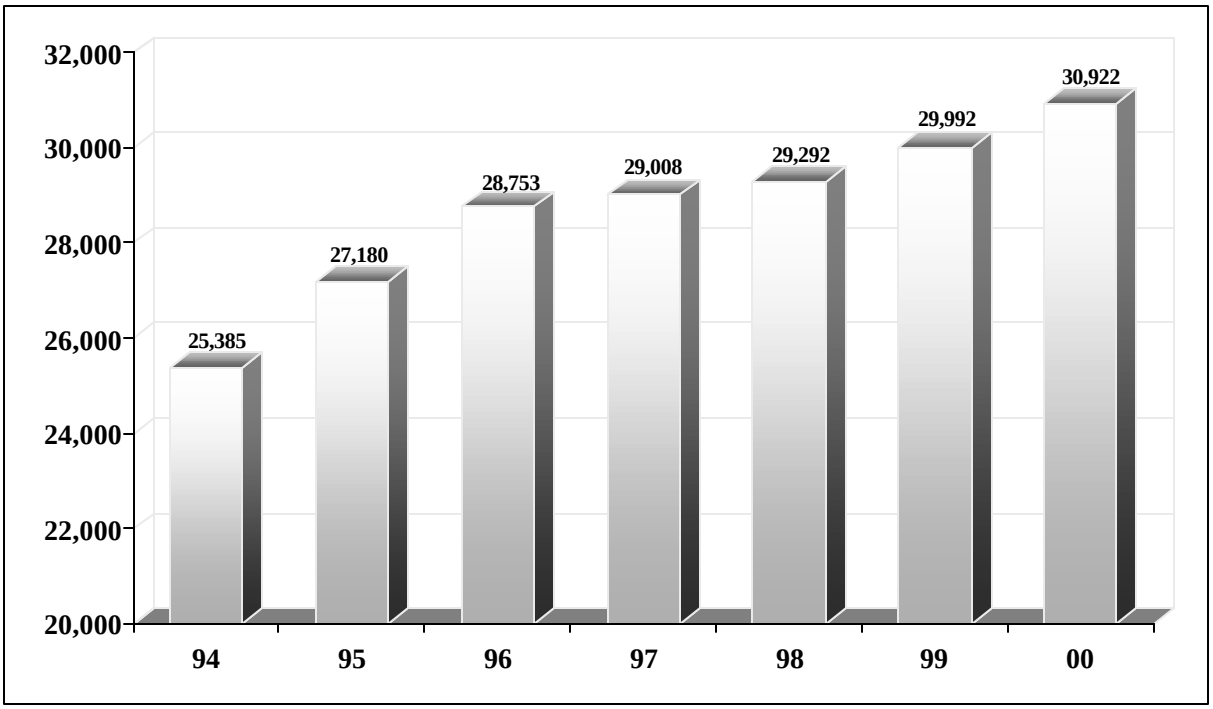
An aging workforce

The increasing age of the workforce—which includes "baby-boomers" employed in state and county governments—and the growing number of retirees are other key factors driving up the cost of health benefits.

- The average age of Hawaii's 59,191 active employees is 45.5 years with an average 13 years of service—which means many workers are approaching an age bracket when health care and retirement needs take on added importance.
- The number of retirees has been rising steadily, from 25,000 in FY94 to 31,000 in FY00 *(see Figure 5, below).*

The numbers show that the state will be contributing to the health benefits of an aging workforce and increasing number of retirees, who traditionally require the most health care, at a time when health care costs are sharply escalating.

Figure 5: Growth in retirees covered under Health Fund, FY94-FY00



"Adverse Selection" drives up costs

The inadvertent segregation of high-risk and low-risk public employees in different health plans is posing a serious threat to the state budget and the health benefits system.

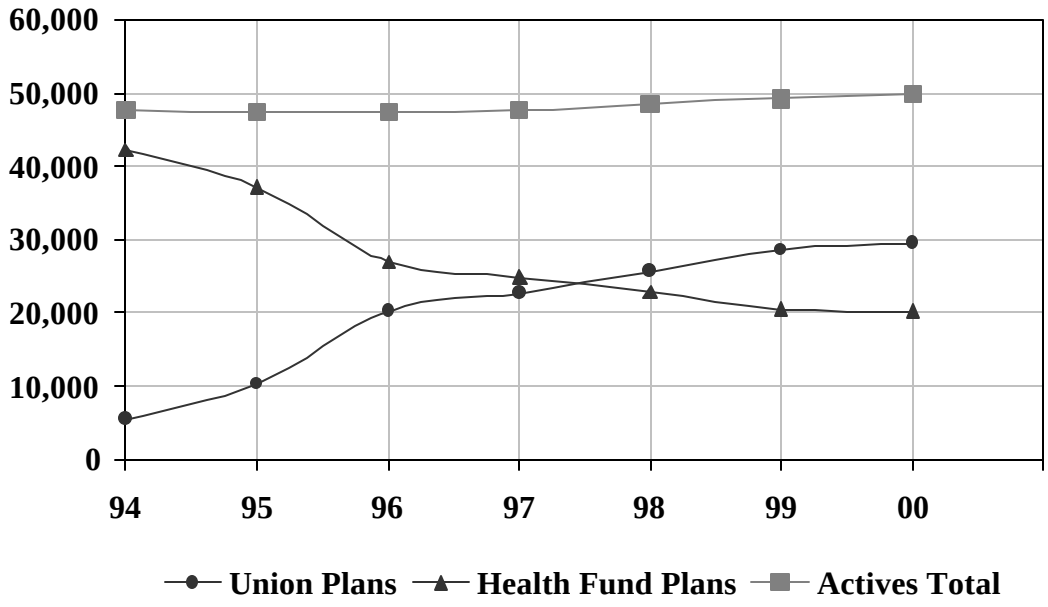
Hawaii is the only state that allows public employees to choose between the Health Fund and union-sponsored plans. In 1999, the Auditor said this choice created a phenomenon called "adverse selection—the migration of low-risk active employees into union-sponsored health plans which left mostly high-risk employees in the Health Fund. Between FY94 and FY00, the number of low-risk active employees in Health Fund plans fell drastically from approximately 42,000 to 20,000, but skyrocketed in union plans from 5,000 to 30,000 *(see Figure 6, below).*

This migration occurred because low-risk employees, who typically have smaller families and require only occasional visits to the doctor's office and generally less medical treatment, moved from the Health Fund to more inexpensive union plans. The Health Fund's plans, meanwhile, became the preferred plan for high-risk beneficiaries who were more likely to experience major medical expenses or hospitalization. The

Auditor noted that "the employee population with family coverage under the health fund plans is older than those with family coverage under the union plans."

"The large growth in union plan enrollment and adverse selection have increased the overall cost of the (Health Fund) program to employers more than these costs would have increased without such growth," reported the Auditor. "The State and counties can expect such higher employer costs to continue until actions are taken to reduce adverse selection."

Figure 6: Enrollments in Health Fund and employee organization medical plans - Active employees, FY94-FY00, state and counties



"Porting"

Each month, state law requires the Health Fund to pay employer contributions for the coverage of active employees enrolled in union plans. Collective bargaining sets the contribution amount which is transferred, or "ported," from the Health Fund to the union plans. The contribution amount is based on the cost of Health Fund plans with the highest enrollment. And, the Auditor said Health Fund plans typically cost more than union family plans.

In FY94, the Health Fund "ported" $10.9 million in FY94. This amount rose to $102.0 million in FY01. The "ported" employer contributions resulted in significantly higher employer costs and increased premiums for all Health Fund beneficiaries, said the Auditor.

The Solution: The Hawaii Employer-Union Health Benefits Trust Fund

In an effort to safeguard the future of health benefits in the State of Hawaii, the Hawaii State Legislature enacted a law in 2001 establishing a 10-member Board of Trustees to govern the new Hawaii Employer-Union Health Benefits Trust Fund.

The new law includes a number of provisions that will help control the rising costs of health premiums for beneficiaries and public employers and safeguard the future fiscal security of health benefits.

Single trust fund eliminates threats to health benefits

The new law creates a single employer-union trust to deliver employee health benefits. Placing all employees—actives and retirees—in a single, larger group of beneficiaries will eliminate "adverse selection," "porting," higher premium costs, and duplicative administrative expenses. In addition, the Auditor pointed out that the negotiating power of the new trust with insurance carriers would be enhanced:

> *"We recommend combining the health fund program and all of the union programs into one overall health benefit program. The presence of union plans competing with the health fund for enrollees has resulted in significantly higher employer contribution costs for active employees than would have been the case without such competition. This trend toward higher employee contributions will continue in the foreseeable future as long as the present program continues. The existence of union plans has also increased the premium costs for participants enrolled in health fund plans…. Our survey of 16 public employee health benefits program in other states found that none currently have competing benefit programs, offering both government plans and union plans."*

Board of Trustees to represent employer and unions

A 10-member board—equally representing the interests of unions and public employers—will govern the Trust Fund. Using lists of nominees submitted by unions and state and county employers, the governor appointed five board members to represent unions (with one representing retirees) and five members to represent public employers. The board convened for the first time on January 9, 2002 and will implement the new trust, starting July 1, 2003.

Trust Fund offers flexibility and a choice of health plans.

The board will provide health and other benefit plans—similar to existing plans—at an affordable cost to both public employers and public employees. The board will have full flexibility to determine the types of plans that will be offered and to design health care benefits packages that meet the needs of beneficiaries. Benefit eligibility, as determined by current law, basically remains the same.

Beneficiaries will have a choice of health plans and the freedom to make personal decisions to best meet their own needs. Public employer contributions for active employees will be determined through collective bargaining. (However, beginning in FY04, public employer contributions will be at specified dollar amounts rather than a percentage basis.)

Effects on retirees

Creation of the new Trust Fund reflects the state's desire to provide retirees hired before June 30, 2001 with the basic health benefits they were assured of receiving when they first entered government service. However, funding that commitment will change, in order to rein in rising health care costs.

Under the new law, the Trust Fund's board will establish the employer contributions for retirees by formula—using existing rates adjusted for inflation. The board will use fixed statutory contributions beginning in FY04, with annual adjustments thereafter to be determined by changes to the Medicare Part B premium rate. These amounts will be sufficient so the Board can provide a basic package of benefits comparable to existing plans offered through medical, dental and other health plans for pre- and post-Medicare retirees.

Retirees would be able to maintain the full slate of basic benefits with employer contributions generally covering the total premium cost. The delivery of those benefits could change to require beneficiaries to move to new physician networks. This could mean changing from a fee-for-service plan, such as HMSA, to a Health Maintenance Organization, such as Kaiser or to a Preferred Provider Organization Plan. In addition, the Board has the flexibility to design other plan options which beneficiaries could purchase to enhance their coverage.

For employees hired after June 30, 2001, health benefits, upon retirement, will be limited. Employer contributions will be for retirees only, and contributions for surviving spouses and dependents will be reduced by one-half.

These changes will allow the Trust Fund to control the cost of health benefits and move the state away from "blank check" coverage of retirees' health benefits to an approach that balances the provision of health benefits with the cost of that service. In the past, state law specified the type of medical and other benefits that must be provided to retirees and required the public employer to pay 100 percent of the cost for most retirees. The law required the state Health Fund to design health benefits plans but did not define any cost limitations. But the rising costs of health care make it difficult to continue funding health coverage in this manner. The cost of health benefits must be defined, as the Auditor recommends, to safeguard the future of the health benefits system.

Active Employees: New plans offer flexibility, value

For many years, the available choices in health care plans have remained unchanged. Employees have chosen to carry some kind of coverage or have opted not to carry any type of coverage. For those who sought coverage, the choices in Health Fund plans have been limited to "single" or "family" plans that were designed to fit the needs of many beneficiaries, using a "one-plan-fits-all" approach.

In practice, these plans were designed as a general fit for everyone, and beneficiaries paid for coverage that may not have been needed but was carried as part of the health plan. However, the changing financial landscape of health coverage, in Hawaii and the rest of the country, calls for innovative ways to provide health coverage plans that

fit the needs of employees and the fiscal resources of employers who must work to ensure the future availability of that coverage, as the cost of health care escalates dramatically.

The overall design strategies will explore possibilities to provide beneficiaries flexibility by offering multiple plans and multiple options within those plans. Plans would be designed with contribution rates that recognize differing family needs. Plans offered by the Trust Fund would be tailored more specifically to fit a variety of beneficiaries and their needs, recognizing the diverse composition of today's families.

There would be multiple options available with different contribution rates. Beneficiaries would pay for what they need. For example, the Trust Fund could create a wider range of contribution levels in health plans which could offer various gradients to recognize different family situations:

- Single;
- Single, plus one child;
- Participant and Spouse;
- Participant and Spouse over 65;
- Participant plus Children;
- Participant and Family.

The different gradients would allow beneficiaries, or participants, to pay only for coverage that is needed and to choose how they pay—through higher premiums offering greater protection or a payment at the time of service, which involves higher co-payments.

Possible plans for active employees

The new Trust Fund's Board of Trustees will design and approve new health plans. Plans for consideration are listed below:

1. Triple Option Benefit Plan. This flexible plan would offer participants, at any time, a choice of three plans that provides selection and use of a Primary Care Physician from 1) an exclusive network HMO, or 2) a Preferred Provider Organization alternative network composed of a larger number of physicians and hospitals, and 3) an out-of-network

benefit. This plan offers the greatest amount of flexibility. Reimbursements are based upon the choice of the participant who is not "locked in" to any network. The exclusive, tightly-controlled network provides higher benefits at a lower cost and gives each participant the choice to vary the cost of participation at the time of service. The choice between a network and non-network is made at the time of service. Participants would have the flexibility to choose plans that offer:

- In-Network benefit (HMO) – 100 percent coverage for hospital charges if participant is referred by a Primary Care Physician (PCP). Co-payment of $10 for office visits with PCP or specialist referred by PCP. Co-payment of $10 for annual physicals. Participant receives routine and ordinary services and care. Co-payment of $35 in the network for emergency room service.
- Preferred Provider Organization (PPO) Network benefit – 85 percent of reasonable and customary charges after an annual deductible of $150, including non-HMO network hospitals in the PPO network. Physician charges and routine medical care. Emergency room co-payment in a non-network PPO hospital subject to a $50 per use deductible.
- Out of Network benefit – Physician and hospital expenses paid at 70 percent after $150 deductible.

2. Low-Option HMO. This plan could be offered with a minimal employee contribution to the "single" participant and is ideally suited for the younger, healthier participant who does not want to pay a premium and requires only minimal office visits to his or her doctor. The participant pays a contribution through co-payments at the time of service.

- Participant has access to an exclusive provider network with no out-of-network benefit;
- Annual deductible: none;
- Other routine and approved care: No co-payments;
- Physician office visits: $15 co-payment;
- Hospital confinement or use of emergency room: $50 co-payment;
- Drugs, per prescription: $12 co-payment.

3. High Option HMO. This plan is ideally suited the younger, healthier participant seeking more benefits than those offered in Low Option HMO.

- Participant has access to an exclusive provider network with no out-of-network benefit;
- Annual deductible: None;
- Physician office visits: $8 co-payment;
- Hospital care: No co-payment;
- Emergency room use: $35 co-payment;
- Routine and approved care: No co-payment;
- Prescriptions: $10 co-payment per prescription, or $10 for 90-day mail order supply.

4. PPO Medical Plan.

- Physician office visits: $15 co-payment;
- Hospital care: $150 co-payment per confinement;
- Emergency room use: $50 co-payment;
- Other routine supplies 80 percent coverage;
- Annual lifetime maximum of $2 million.

5. Catastrophic Medical Plan. This plan would be ideal for participants who may have health coverage elsewhere, such as a spouse's plan, or wish to self-insure.

- 90 percent coverage of routine medical expenses for physician, hospital and other ordinary care up to a maximum per year of $1,000 of benefits paid;
- All covered expenses subject to an annual deductible of $2,500;
- After satisfaction of the annual deductible, expenses are reimbursed at 90 percent of reasonable and customary medical expenses.

6. Family Budget Package for Medical, Dental, Vision Care Plan. This plan could combine the components of medical, dental, vision, orthodontic, and prescription drug coverage under one umbrella plan. Beneficiaries would be limited to a maximum level of

payments per year in each component. Low utilization in one component produces credits that may be used in other components. A family would be able to budget its payments, so that low or no utilization of orthodontic services, for example, would result in using those credits for other needs such as vision care.

- Up to $4,000 per family participant paid in medical expenses at 90 percent of usual and customary charges, or vision care or prescription, dental and orthodontic benefits per year, per covered participant;
- When eligible medical expense exceeds $7,500, the plan pays 80 percent of all reasonable medical expenses without a maximum;
- Prescription benefits paid up to the combined maximum at 80 percent of the discounted retail charges: vision benefits paid up to $250 per participant; dental benefits including orthodontic benefits paid at 80 percent of reasonable and customary charges, subject to pre-authorization.

7. Prescription Plan.

- Generic: $10;
- Formulary Brand: $15;
- Non-formulary Brand: $30.

8. Low Option Prescription Plan. This plan provides coverage for generic and formulary drugs only. The co-payment equals 20 percent of the cost of all prescriptions dispensed at retail. Mail order prescription drug co-payments are as follows:

- Generic: $20 for 90-day supply;
- Brand: $30 for 90-day supply.

9. Vision Plan High and Low Option.

- A high option plan could cover examinations, lenses and frames, contacts, and laser surgery up to an annual maximum reimbursement of $150 per participant, with no network use required.

- A lower option plan could offer fixed dollar co-payments for examinations limited to one per year at $10 per exam, with a $60 annual allowance per participant for eyeglasses and lenses and a $100 allowance per two-year period for contact lenses.

10. Dental Network.

- 100 percent of preventive, cleaning, and x-ray services, subject to an annual maximum benefit for all services;
- 60 percent of restorative, endontic, periodontic and prosthondonitic services.

11. Life Insurance for Dependents and Spouses. Optional life insurance on spouses and children at a fixed amount per child of $5,000 and multiples of $5,000 - $50,000 per spouse.

Possible plans for retirees

For retirees, contributions set by law are geared to pay the full cost of basic coverage. Retirees will have the option to choose other plans with some required contributions. And, all Medicare-eligible retirees will cover some expenses due to changes in integration with Medicare, as required by state law. Retirees may also opt to reduce benefits to obtain money for long-term care and other new plans such as medical savings accounts that reimburse expenses which are out of the ordinary.

Possible plans for retirees under 65

(Plans are designed to stay within employer contribution cap.*Contribution for first year of plan, 2004, is adequate to continue no retiree contribution for this plan. However, subsequent increases in plan costs may exceed increases in employer contributions.**)

1. High Option HMO**

- Exclusive provider network with no out-of-network benefit;
- Annual deductible: none
- Physician office visits: $8 co-payment

- Hospital care: No co-payment
- Emergency room use: $35 co-payment
- Routine and approved are: No co-payment
- Drug: $10 co-payment per prescription, or $10 for 90-day supply.

2. Low Option HMO*

- $15 co-payment for retirees under 65.
- $12 drug co-payment for retirees under 65.
- Produces credit to be used to purchase Long-Term Care insurance and adjusts co-payments to keep the plan within cost guidelines;
- Pays benefits at the same level as Medicare Plus Choice plans but provides a lifetime benefit credit which rewards low usage in subsequent years;
- Years of low use produces credit that is carried over to subsequent years to be used to provide higher reimbursement of expenses for catastrophic coverage or in-home health care expenses.

3. Retiree PPO Medical Plan

- Physician office visit: $15 co-payment;
- Hospital use co-payment: $150 per confinement;
- Emergency Room use: $50;
- Other routine supplies: 80%;

4. Prescription Plan

- Generic: $10
- Formulary Brand: $15
- Non-formulary Brand: $30

5. Low Option Prescription Plan*

- Provides for coverage for generic and formulary prescription drugs only;
- Co-payment equals 20 percent of the cost of all retail prescriptions;
- Generic: $20 for a 90-day supply;

- Brand: $30 for a 90-day supply;

6. Vision High Option**

- Coverage for examinations, lenses and frames, contacts and laser surgery up to an annual maximum reimbursement of $150 per participant;
- No network usage required.

7. Vision Low Option*

- Fixed dollar co-payment for examinations limited to one per 12-month period at $10 per examination;
- Allowance for eyeglasses and lenses $60 per year per participant;
- Allowance for contact lenses $100 per 24-month period;
- Discounted provider network.

8. Dental DMO Plan*

- Examination, x-rays, and cleaning limited to those of the network provider;
- Fixed-dollar co-payments provided for all other non-routine services from $10 - $130.

9. Life Insurance*

Possible plans for retirees over 65

(Plans are designed to stay within employer contribution cap. * Contribution for first year of plan, 2004, is adequate to continue no retiree contribution for this plan. However, subsequent increases in plan costs may exceed increases in employer contributions.**)

1. Kaiser Senior Advantage*

- Integrated with Medicare: $8 co-payment;
- Prescription drug: $10 co-payment.

2. PPO Medical Plan

- Physician office visit: $15 co-payment;
- Hospital use co-payment: $150 per confinement;
- Emergency Room use: $50;
- Other routine supplies: 80 percent;
- Annual lifetime maximum: $2 million.

3. Medicare Plus Choice HMO*

- Physician office visits: $10 co-payment;
- Specialist and surgeon: $10 co-payment;
- 100% of all other usual and customary care and other services at rates specified by Medicare;
- Prescription drug co-payment: $10 generic, $15 formulary brand, $30 non-formulary brand.

4. Prescription Plan

- Generic: $10
- Formulary Brand: $15
- Non-formulary Brand: $30.

5. Low Option Prescription Plan*

- Provides for coverage for generic and formulary prescription drugs only;
- Co-payment equals 20 percent of the cost of all retail prescriptions;
- Generic: $20 for a 90-day supply;
- Brand: $30 for a 90-day supply.

6. Vision High Option**

- Coverage for examinations, lenses and frames, contacts and laser surgery up to an annual maximum reimbursement of $150 per participant;

- No network usage required.

7. Vision Low Option*

- Fixed dollar co-payment for examinations limited to one per 12-month period at $10 per examination;
- Allowance for eyeglasses and lenses $60 per year per participant;
- Allowance for contact lenses $100 per 24-month period;
- Discounted provider network.

8. Dental DMO Plan*

- Examination, x-rays, and cleaning limited to those of the network provider;
- Fixed-dollar co-payments provided for all other non-routine services from $10 - $130.

9. Life Insurance*

10. $50 Reimbursement for Medicare Part B Premium

Conclusion: Safeguarding the future

The state's ability to pay for health coverage in the immediate future is in serious jeopardy. If unchecked, the rising cost of health care coverage threatens the benefits retirees and active employees receive today and expect to receive in the future. The prospect of Health Fund costs bankrupting the state budget is real. Health Fund appropriations are taking up a larger and larger share of overall spending each year, consuming more and more of the state's limited financial resources.

The Legislative Auditor has recommended the reforms which are a part of Act 88. Fundamental reforms to public employee health benefit plans are needed to control the skyrocketing costs of health care benefits. Key reforms will bring all public employees into a single benefits program which eliminates "adverse selection" and "porting"—major forces that have driven up the cost of benefits—and will provide the Trust Fund

with greater leverage to negotiate favorable rates with health insurance carriers. Also, health benefit contributions for retirees will be calculated using defined contribution or defined cost plans for retiree health benefits.

If "porting" and "adverse selection" were allowed to continue, in light of rising health care costs, the only remedies available to the state would be tax increases, reductions in state programs and services, reductions in or elimination of health benefits to retirees and active employees, and other drastic budget-cutting measures.

The Hawaii Employer-Union Health Benefits Trust Fund and its much-needed reforms will change the delivery of health care to active employees and retirees and safeguard their benefits. The Trust Fund will provide participants with health benefit plans that are comparable to existing ones. The Trust Fund also provides the state and taxpayers a more cost-efficient health benefits system that contributes to the stability of Hawaii's fiscal strength. The new reforms will help the health benefits system for public employees and retirees avoid a fiscal disaster that would otherwise lead to a more serious deterioration in the quality of life for all beneficiaries—and all people—in the State of Hawaii.

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